STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES

APPLICATION FOR MENTAL HEALTH AGENCY LICENSE

DATE: _____

APPLICATION IS FOR: NEW LICENSE_____ RENEWAL OF LICENSE_____

ADD A SERVICE_____ ADD A SITE_____

NAME OF FACILITY/AGENCY_____

ADDRESS: MAILING ADDRESS: (if different)

_____ _____

_____ _____

_____ _____

(City, State, Zip) (City, State, Zip)

COUNTY_____

NAME/TITLE OF ADMINISTRATOR/OPERATOR:_____

PHONE#_____ FAX#_____ EMAIL_____

NAME OF CONTACT PERSON:_____

PHONE#_____ FAX#_____ EMAIL_____

NAME OF EXECUTIVE DIRECTOR:_____

SOCIAL SECURITY # OR EMPLOYER ID#_____

CORPORATION NAME/ADDRESS (if different) _____

_____

_____

TYPE OF FACILITY/AGENCY:

Individual Proprietorship: _____ Partnership: _____

Non-Profit Corporation: _____ For-Profit Corporation: _____

Tribal Government: _____ Parent Co-op: _____

Church: _____ Other (describe): _____

CURRENT LICENSES/CERTIFICATES:

Type: _____ Terms: _____ Exp. Date: _____

Type: _____ Terms: _____ Exp. Date: _____

WAIVER / EXCEPTION REQUEST OR RE-REQUEST (If applicable)

_____

_____

_____

_____

I/We have received and read the rules for the licensing and /or certification process. I/We understand that this application authorizes representatives of the Department of Health and Human Services and the State Fire Marshall's Office (if applicable) to make such visits and inspections as may be necessary to ensure that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We also understand that the signing of this application effectively serves as a release of information and gives permission to the Department of Health and Human Services to obtain any criminal or protective records information which may be on file in any Country, State or Federal Office.

I/We further certify that all information contained in this application (including addendum) is complete and accurate.

SIGNATURE REQUIRED:

_____/ DATE: _____
Applicant/Operator/Administrator

_____
Type or Print Name

_____/ DATE: _____
Board President

_____
Type or Print Name

FURTHER INSTRUCTIONS:

1. COMPLETE THE ATTACHED ADDENDUM SPECIFIC TO THE TYPE OF LICENSURE OR CERTIFICATION THAT IS BEING APPLIED FOR.

2. SUBMIT ALL ITEMS REQUESTED IN THE "PLEASE SUBMIT" SECTION OF THE FORM.

ADDENDUM
APPLICATION FOR – MENTAL HEALTH AGENCY

SERVICES BEING APPLIED FOR:
(Include Module Type, Specific Service, and each location from which service will be delivered. Attach additional sheets if necessary.)

MODULE: ________________________________ SERVICE: ___________________________________
LOCATION ADDRESS: ____

MODULE: ________________________________ SERVICE: ___________________________________
LOCATION ADDRESS: ____

MODULE: ________________________________ SERVICE: ___________________________________
LOCATION ADDRESS: ____

MODULE: ________________________________ SERVICE: ___________________________________
LOCATION ADDRESS: ____

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LOCATION ADDRESS: ____

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LOCATION ADDRESS: ____

MODULE: ________________________________ SERVICE: ___________________________________
LOCATION ADDRESS: ____

MODULE: ________________________________ SERVICE: ___________________________________
LOCATION ADDRESS: ____

MODULE: ________________________________ SERVICE: ___________________________________
LOCATION ADDRESS: ____

MODULE: ________________________________ SERVICE: ___________________________________
LOCATION ADDRESS: ____

FOR EACH SERVICE YOU PROVIDE LIST THE MAXIMUM TOTAL NUMBER OF CLIENTS YOUR AGENCY WILL SERVE AT ALL LOCATIONS, THE AGE RANGE, AND GENDER.
(Use additional sheets if necessary.)

SERVICE: _____ # OF CLIENTS_____AGE RANGE_____GENDER_____

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SERVICE: _____ # OF CLIENTS_____AGE RANGE_____GENDER_____

ALL APPLICANTS PLEASE SUBMIT:

1. Completes application
2. $25 Fee – Make check payable to: TREASURER, STATE OF MAINE
3. Organizational Chart
4. List of Governing Body Members/Offices Held/Addresses
5. Fire Inspection Form (New Sites)
6. Staff Roster
7. ADA Self-Evaluation Form (New Sites)
8. Program Descriptions
9. Program Admission criteria for each program
10. Any new or changed policies
11. Submit current water test for each site not on public water

FIRST TIME APPLICANTS ALSO MUST SUBMIT:

1. Articles of Incorporation
2. Complete Policy and Procedure Manual
3. Sample Client File
4. Equal Opportunity Questionnaire & Documentation

SUBMIT application to:

Department of Health and Human Services
ATTN: Community Services Programs
11 State House Station
442 Civic Center Drive
Augusta, ME 04333

Phone: (207) 287-9250 Fax: (207) 287-9252 TTY: (800) 606-0215

STAFF ROSTER

FULL NAME_______________________________ TITLE _______________ DATE OF BIRTH_______________
EDUCATION/DEGREE___________________LICENSE/CERTIFICTION_________________________________
SUPERVISOR____ TITLE ____________________________________

FULL NAME_______________________________ TITLE _______________ DATE OF BIRTH_______________
EDUCATION/DEGREE___________________LICENSE/CERTIFICTION_________________________________
SUPERVISOR____ TITLE ____________________________________

FULL NAME_______________________________ TITLE _______________ DATE OF BIRTH_______________
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SUPERVISOR____ TITLE ____________________________________

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EDUCATION/DEGREE___________________LICENSE/CERTIFICTION_________________________________
SUPERVISOR____ TITLE ____________________________________

(Use additional sheets if necessary)

FIRE INSPECTION REQUEST & ADDRESS CHANGE FORM
Type of License/Certification:_____

FORM MUST BE COMPLETED BY:
1. New Applicants: Complete one form for each site from which you plan to deliver services and return with your application (NEED ONE FORM FOR EACH SITE)

2. All Applicants: Complete and submit form when you are adding a site, changing your address, or closing a site. (KEEP A COPY OF THE FORM FOR YOUR RECORDS)

MAIN SITE:
Agency Name: _____ Date: _____
Operator/Exec. Director: _____ Phone: _____
Address: Contact Person (If different)
_____ _____
_____
_____ Phone: _____
(City, State, Zip)

DESCRIPTION OF SERVICES: _____
_____

AGE RANGE OF CLIENTS SERVED: _____ MAXIMUM CAPACITY: _____

RESIDENTIAL: _____ NON-RESIDENTIAL: _____

DIRECTIONS TO FACILITY: (Be specific with known landmarks.) _____

COMPLETE ONLY IF CHANGE:
New Program/Agency In Process of Licensure_____

Closing Existing Site _____ Address: _____
_____

Adding New Site _____ Address _____
_____

Moving Office Site Within Same Building _____

NEW SITE: Date of Expected Move: _____
Contact Person: _____ Phone: _____

WATER SOURCE: Municipal _____ Well _____ Other _____

DIRECTIONS TO FACILITY: (Be specific with known landmarks.)_____
_____
_____
_____